Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4812 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

AHMED KHALIFA MD
1415 SOUTH HWY 6 SUITE 400D
SUGARLAND TEXAS 77478

Respondent Name

HARTFORD UNDERWRITERS INSURANCE

Carrier's Austin Representative Box

Box Number 47

MFDR Tracking Number

M4-11-0236-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary taken from *Table of Disputed Services*: "Fee Guideline."

Amount in Dispute: $311.80

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary taken from *Table of Disputed Services*: "Did not submit appropriate modifier for bilateral procedures (2 units)."

Response Submitted by: The Hartford, 300 S. State Street, Syracuse, New York, 13202

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 22, 2010	CPT code 64480 (2 units)	$311.80	$78.37

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the procedures for professional medical services provided in the Texas workers' compensation system on or after March 1, 2008.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated August 24, 2010
   - W1–Wrkrs compensation state fee schedule adjustment. When bilateral prods are performed at the same operative session, use approp procedure code for 1st proc. For 2nd (bilateral) prod add modifier -50 to code. (TWCC MFG pg 65)
   - W1–Wrkrs compensation state fee schedule adjustment. The prod code submitted is not the proper code for this service. Please resubmit with the proper code
   - W1–Workers comp state fee sched adjust. Reimbursement based on Medicare fee schedule for facilities.

Issues

1. Did the requestor bill the services in accordance with 28 Texas Administrative Code §134.203?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.203 (b)(1) "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.
2. Review of the CMS-1500 indicates that the requestor billed the following CPT code:
   - CPT code 72040-26 (1 unit)
   - CPT code 64479 (1 unit)
   - CPT code 64480 (3 units)
   - 77003-26 (1 unit)
3. CMS billing policies indicate that reimbursement is calculated at 150 percent payment adjustment for bilateral procedures. If code is billed with the bilateral modifier or is reported twice on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), base payment for these codes when reported as bilateral procedures on the lower of: (a) the total actual charge for both sides or (b) 150 percent of the fee schedule amount for a single code. If code is reported as a bilateral procedure *and* is reported with other procedure codes on the same day, apply the bilateral adjustment before applying any applicable multiple procedure rules.
4. CPT code 64480 was reported with other procedure codes on the same day, therefore bilateral adjustment is taken before applying any applicable multiple procedure rules. The multiple procedure rules do not apply to CPT code 64480, which contains a status indicator of 0, however the bilateral adjustment applies. Reimbursement is therefore recommended for two units of CPT code 64480.
5. 28 Texas Administrative Code §134.203(c)(1) "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied…"
6. Reimbursement is therefore calculated with the surgery conversion factor of $66.19 and reimbursement is recommended as follows:
   - CPT code 64480 (2 units)

     Status indicator 0 – 150% reimbursement

     MAR = $156.18 x 150% = $234.27

     Insurance carrier paid $155.90 - $234.27 = $78.37

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $78.37.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $78.37 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 3, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.